

1  
FOR STATE  
HEALTH DEPT.

8987

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		c. LENGTH OF STAY IN 1b <u>All life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>W</u> Last <u>Ball</u>		4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1925</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Ball</u>		14. MOTHER'S MAIDEN NAME <u>Willie M. Pugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>William W. Ball, North East, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>North East River</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> <u>a.m.</u> <u>8</u> <u>7</u> <u>19 58</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>North East River</u>	
20f. (City or town) <u>North East Cecil Md.</u>		20g. (County) <u>Cecil</u>	
20h. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Will Woodson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-8-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem.</u>		22d. LOCATION (City, town, or county) <u>North East Cecil Md.</u>	
22e. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Shaw</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Shaw</u>	
22g. ADDRESS <u>North East Md</u>		22h. REC'D BY REGISTRAR <u>AUG 13 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, 3 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 Film G233 8-29-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08974

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Elkton b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berne's Haven Nursing Home		d. STREET ADDRESS 1224 E. Main St. Elkton Md	
3. NAME OF DECEASED (Type or print) Bertha Dunbar Benneil		4. DATE OF DEATH August 18th 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872 Sept 24 1872
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		9b. KIND OF BUSINESS OR INDUSTRY none	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. FATHER'S NAME William Dunbar		12. MOTHER'S MAIDEN NAME Sarah Maddy	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		14. SOCIAL SECURITY NO. none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bertha Dunbar Phillips - Elkton Md		18. ADDRESS (Street, city or town, state) Elkton - Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO General Arterio Sclerosis about 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with mental deterioration 5 yrs (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1948 to Aug 18th 1958, that I last saw the deceased alive on Aug 11 - 1958, and that death occurred at 3:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE H. H. McLaughlin		DATE SIGNED	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-1958	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Rappin Funeral Home		24b. REGISTRAR'S SIGNATURE Arthur L. House	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John J. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>65</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1885</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Retired</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Oct 10 1910</i></p>	
<p>9. NAME OF WIFE <i>Anna M. Smith</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1950</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John J. Smith</i></p>		<p>16. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	

1. This certificate is to be filled out by the physician or other person who has attended the deceased.

2. The name of the deceased must be given in full, and the date of birth must be given in full.

3. The sex must be given.

4. The age must be given in full.

5. The place of birth must be given in full.

6. The occupation must be given in full.

7. The marital status must be given in full.

8. The date of marriage must be given in full.

9. The name of the wife must be given in full.

10. The date of death must be given in full.

11. The place of death must be given in full.

12. The cause of death must be given in full.

13. The medical history must be given in full.

14. The signature of the physician must be given in full.

15. The signature of the registrar must be given in full.

16. The signature of the deceased must be given in full.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8988

## CERTIFICATE OF DEATH

08975

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Cecil</b>		STATE <b>Ma</b>		COUNTY <b>Cecil</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>North East</b>		LENGTH OF STAY (in this place) <b>2 1/2 Mos.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pratt Nurseing Home</b>		STREET ADDRESS (If rural give location) <b>French Town Rd.</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <del>KATE</del> <b>Katherine BERRY.</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 30 19 58</b>			
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>Jan. 12, 1871</b>	<b>9. AGE last birthday</b> <b>87</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Private Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>William Berry</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Susanna Gillespie</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, <b>No</b> ) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>215-32-2446</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs J.P. Anderson, Perryville, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>443X</b> IMMEDIATE CAUSE (A) <b>MYOCARDIAL FAILURE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>C. V. A.</b>				<b>9 days</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Hypertensive Cardiovascular Dis.</b>				<b>Years.</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>MYOCARDITIS CHRONIC.</b>				<b>Years.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) (Second) <b>M.</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8-21, 19-58, to 8-30, 19-58, that I last saw the deceased alive on 8-30, 19-58, and that death occurred at 11:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>W. H. K. K. K.</i>		<b>M.D.</b> <b>NORT EAST</b>		<b>ADDRESS</b> (Street, city, town, state) <b>Port Deposit, Md.</b>		<b>DATE SIGNED</b> <b>8-30-58</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>9-3-1958</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Asbury Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>William S. K. K.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. H. K. K. K.</i>			
<b>DATE</b> <b>SEP 2 '58</b>		<b>ADDRESS</b> <b>Perryville, Md.</b>					





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08976

8975

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>18 N. Bentalow</b>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Byrd</b> Last <b>Byrd</b>				4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1882</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Savannah, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lemuel James</b>				14. MOTHER'S MAIDEN NAME <b>Sylvia Flood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Henry L. Byrd</b>		Address <b>909 N. Stricker St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture of right tibia fibula and general</b> DUE TO (c) <b>vascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Head on collision of automobiles</b>					
20c. TIME OF INJURY Month, Day, Year <b>8/16/58</b> Hour <b>8:15</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 1</b>		20f. (City or town) <b>Rising Sun</b> (County) <b>Cecil</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. R. C. Dodson</b>		EXAMINER'S NAME (Type) <b>Dr. R. C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/2/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W.H. Calvary Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto.</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Katie R. Williams</b>				ADDRESS <b>Schroeder St</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinner</b>	





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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BAL

8989

## CERTIFICATE OF DEATH

08977

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Cecil</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Port Deposit, Rural</b>		LENGTH OF STAY (in this place) <b>40 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Port Deposit, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Canal Station</b>		STREET ADDRESS (If rural give location) <b>Canal Station</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>James Carrell</b>				<b>4. DATE OF DEATH</b> (Month) <b>Aug.</b> (Day) <b>30</b> (Year) <b>1958</b>			
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>April 1, 1883</b>	<b>9. AGE last birthday</b> <b>75</b> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Georgia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>212-25-6278</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>John Stively, Nottingham, Pa.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>151X</b> IMMEDIATE CAUSE (A) <b>Carcinoma of Stomach</b>						<b>6 months</b>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>July 1958</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Carcinoma Stomach</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>June 1958</b> to <b>Aug 30, 1958</b> that I last saw the deceased alive on <b>Aug 30, 1958</b> and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Carroll Johnson M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>Port Deposit, Md.</b> <b>DATE SIGNED</b> <b>8/31/58</b>			
<b>23. BURIAL, CREMATION, REINTERMENT (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>9-2-1958</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Jones Memorial Cem.</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
<b>24. REC'D BY REGISTRAR</b> <b>SEP 2 '58</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hays</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Carroll Johnson &amp; Son Perryville, Md.</b>			

UNCLASSIFIED

1  
This document contains information that is exempt from public release under the provisions of the Freedom of Information Act, 5 U.S.C. 552, and is being furnished to you for your information only. It is not to be distributed outside your agency or used for any purpose other than the one for which it was furnished to you.

# CERTIFICATE OF DEATH

8929

1. NAME OF DECEASED Cecil		2. SEX Male		3. AGE 45 yrs	
4. PLACE OF BIRTH Port Deposit, Md.		5. RACE Caucasian		6. OCCUPATION Cannal Station	
7. USUAL RESIDENCE PRIOR TO DEATH Cecil		8. MARITAL STATUS Married		9. DATE OF DEATH April 1, 1958	
10. PLACE OF DEATH Cecil		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED Cecil		14. SIGNATURE OF WITNESS John S. Davis		15. SIGNATURE OF PHYSICIAN John S. Davis	
16. SIGNATURE OF CLERK John S. Davis		17. SIGNATURE OF MINISTER John S. Davis		18. SIGNATURE OF BURIAL OFFICER John S. Davis	
19. SIGNATURE OF CORONER John S. Davis		20. SIGNATURE OF JURY John S. Davis		21. SIGNATURE OF JUDGE John S. Davis	
22. SIGNATURE OF DISTRICT ATTORNEY John S. Davis		23. SIGNATURE OF COUNTY CLERK John S. Davis		24. SIGNATURE OF STATE CLERK John S. Davis	
25. SIGNATURE OF SECRETARY OF HEALTH John S. Davis		26. SIGNATURE OF ASSISTANT SECRETARY John S. Davis		27. SIGNATURE OF DEPUTY ASSISTANT SECRETARY John S. Davis	
28. SIGNATURE OF CHIEF OF BUREAU John S. Davis		29. SIGNATURE OF ASSISTANT CHIEF John S. Davis		30. SIGNATURE OF DEPUTY ASSISTANT CHIEF John S. Davis	
31. SIGNATURE OF SPECIAL AGENT John S. Davis		32. SIGNATURE OF INVESTIGATOR John S. Davis		33. SIGNATURE OF DETECTIVE John S. Davis	
34. SIGNATURE OF OFFICER John S. Davis		35. SIGNATURE OF SERGEANT John S. Davis		36. SIGNATURE OF CAPTAIN John S. Davis	
37. SIGNATURE OF MAJOR John S. Davis		38. SIGNATURE OF LIEUTENANT John S. Davis		39. SIGNATURE OF PRIVATE John S. Davis	
40. SIGNATURE OF CORP John S. Davis		41. SIGNATURE OF PVT John S. Davis		42. SIGNATURE OF PFC John S. Davis	
43. SIGNATURE OF PFC John S. Davis		44. SIGNATURE OF PFC John S. Davis		45. SIGNATURE OF PFC John S. Davis	
46. SIGNATURE OF PFC John S. Davis		47. SIGNATURE OF PFC John S. Davis		48. SIGNATURE OF PFC John S. Davis	
49. SIGNATURE OF PFC John S. Davis		50. SIGNATURE OF PFC John S. Davis		51. SIGNATURE OF PFC John S. Davis	
52. SIGNATURE OF PFC John S. Davis		53. SIGNATURE OF PFC John S. Davis		54. SIGNATURE OF PFC John S. Davis	
55. SIGNATURE OF PFC John S. Davis		56. SIGNATURE OF PFC John S. Davis		57. SIGNATURE OF PFC John S. Davis	
58. SIGNATURE OF PFC John S. Davis		59. SIGNATURE OF PFC John S. Davis		60. SIGNATURE OF PFC John S. Davis	
61. SIGNATURE OF PFC John S. Davis		62. SIGNATURE OF PFC John S. Davis		63. SIGNATURE OF PFC John S. Davis	
64. SIGNATURE OF PFC John S. Davis		65. SIGNATURE OF PFC John S. Davis		66. SIGNATURE OF PFC John S. Davis	
67. SIGNATURE OF PFC John S. Davis		68. SIGNATURE OF PFC John S. Davis		69. SIGNATURE OF PFC John S. Davis	
70. SIGNATURE OF PFC John S. Davis		71. SIGNATURE OF PFC John S. Davis		72. SIGNATURE OF PFC John S. Davis	
73. SIGNATURE OF PFC John S. Davis		74. SIGNATURE OF PFC John S. Davis		75. SIGNATURE OF PFC John S. Davis	
76. SIGNATURE OF PFC John S. Davis		77. SIGNATURE OF PFC John S. Davis		78. SIGNATURE OF PFC John S. Davis	
79. SIGNATURE OF PFC John S. Davis		80. SIGNATURE OF PFC John S. Davis		81. SIGNATURE OF PFC John S. Davis	
82. SIGNATURE OF PFC John S. Davis		83. SIGNATURE OF PFC John S. Davis		84. SIGNATURE OF PFC John S. Davis	
85. SIGNATURE OF PFC John S. Davis		86. SIGNATURE OF PFC John S. Davis		87. SIGNATURE OF PFC John S. Davis	
88. SIGNATURE OF PFC John S. Davis		89. SIGNATURE OF PFC John S. Davis		90. SIGNATURE OF PFC John S. Davis	
91. SIGNATURE OF PFC John S. Davis		92. SIGNATURE OF PFC John S. Davis		93. SIGNATURE OF PFC John S. Davis	
94. SIGNATURE OF PFC John S. Davis		95. SIGNATURE OF PFC John S. Davis		96. SIGNATURE OF PFC John S. Davis	
97. SIGNATURE OF PFC John S. Davis		98. SIGNATURE OF PFC John S. Davis		99. SIGNATURE OF PFC John S. Davis	
100. SIGNATURE OF PFC John S. Davis		101. SIGNATURE OF PFC John S. Davis		102. SIGNATURE OF PFC John S. Davis	

8990

## CERTIFICATE OF DEATH

68978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East (Rural)			
c. LENGTH OF STAY IN 1b 20 years				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Mae Last Clymer				4. DATE OF DEATH Month August Day 6 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1868	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Elisha Darlington				14. MOTHER'S MAIDEN NAME Sidney Darlington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Wm. T. Russell, Sr.		Address North East (Rural)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis, left.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1958, to 6 Aug 1958, that I last saw the deceased alive on 5 Aug 1958, and that death occurred at P. A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner				ADDRESS (Street, city or town, state) North East, Md.		DATE SIGNED 8 Aug '58	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-58		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE AUG 12 1958	
				24b. REGISTRAR'S SIGNATURE C. E. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH 1900	
NAME OF DECEASED [Name]		SEX [Sex]	
AGE [Age]		RACE [Race]	
PLACE OF BIRTH [Place]		PLACE OF DEATH [Place]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]	
TIME OF DEATH [Time]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF WITNESS [Signature]	
DATE OF REGISTRATION [Date]		PLACE OF REGISTRATION [Place]	

## CERTIFICATE OF DEATH

Reg. Dist. No.

08979

8976

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 Elkton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Josephine</i> First Middle Last <i>Leckman</i>		4. DATE OF DEATH Month <i>8</i> Day <i>7</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 4, 1892</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles W. Stearns</i>		14. MOTHER'S MAIDEN NAME <i>No record</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Arthur Stearns</i> Address <i>Elkton, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Laceration of Left Leg</i> <i>Stomach Injury in Fruit Basket</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ironing Sling</i>		20f. (City or town) <i>Elkton Cecil Md</i> (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>58</i> , to <i>7 Aug</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6 Aug</i> , 19 <i>58</i> , and that death occurred at <i>6:55 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Kreis, Jr</i>		ADDRESS (Street, city or town, state) <i>201 E Main St Elkton, Md</i>	
PHYSICIAN'S NAME (Type) <i>George J. Kreis, Jr</i>		DATE SIGNED <i>7 Aug 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/10/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Trout Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Elkton Del.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Foster Daniels</i> ADDRESS <i>Elkton</i>		24a. REC'D BY REGISTRAR <i>AUG 15 58</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







8991

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GILBERT</b> Middle <b>C.</b> Last <b>COOLING</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1885</b>	
9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Principal</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Zachary T. Cooling</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Lovelace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-22-7196</b>		17. INFORMANT <b>Mrs. Mary B. Cooling, Chesapeake City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150x OESOPHAGEAL OBSTRUCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF OESOPHAGUS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>One month</b> <b>One year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1957</b> to <b>Aug 5, 1958</b> , that I last saw the deceased alive on <b>August 5, 1958</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CHESAPEAKE CITY MD</b> DATE SIGNED <b>8/4/58</b>							
ACTUAL SIGNATURE <b>Henry V. Davis</b>				PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Barton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward H. Hallowell</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

8977

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 397 W. Main		d. STREET ADDRESS 397 W. Main	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Kansoda Day		4. DATE OF DEATH Month 8 Day 22 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH #2z 3-8-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Grundy, Va.	
13. FATHER'S NAME Walter Ashby		14. MOTHER'S MAIDEN NAME Mary Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Wilson		Address Delta, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary DUE TO (b) Cardiac Enlargement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-23-1958	
22c. NAME OF CEMETERY OR CREMATORY Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Grundy, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home Wm A. Luddy		24a. REC'D BY REGISTRAR DATE AUG 26 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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PO. NO. 1

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8992

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 month 6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>718 - 6th Street, N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HALLIE (NMI) FERGUSON</b>				4. DATE OF DEATH Month Day Year <b>August 28, 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1919</b>		9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dishwasher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Handling</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Toney Ferguson</b>				14. MOTHER'S MAIDEN NAME <b>Eva Antony</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>248-16-0642</b>		17. INFORMANT Address <b>Hospital Records, VA Hospital, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> 146X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Carcinoma, squamous cell type of the nasal pharynx</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 - 6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Localized peritonitis around gastrotomy opening</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 22, 19 58</b> to <b>August 28, 19 58</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>S. P. Lacerva</i>		ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Perry Point, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA, M.D.</b>		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/30/58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town or county) (State) <b>South Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Hines</i>				ADDRESS <b>Charleston, S.C.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8098

Name of Deceased		Sex		Age	
Mary Jane, nee		Female		40	
Residence		Place of Birth		Date of Birth	
Wilmington, Mass.		Massachusetts		April 1, 1898	
Cause of Death		Place of Death		Date of Death	
Epidemic Typhus		South Carolina		April 1, 1933	
Occupation		Marital Status		Date of Marriage	
Epidemiologist		Single		None	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Reporter	
April 1, 1933		South Carolina		[Signature]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08982

8978

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Delaware</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Gustav</b> Last <b>Ferro</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1885</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plummer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Residential</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Gustav Ferro, Deceased</b>				14. MOTHER'S MAIDEN NAME <b>Agusta Fischer, Deceased</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>175 28 2212</b>		17. INFORMANT Address <b>Mrs. Grace Ferro 2118 Vernon Avenue Boothwyn, Penna.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis-generalized.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8/20</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Apparent Upper GI-varicosities.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 14, 1958</b> to <b>Aug 20, 1958</b> , that I last saw the deceased alive on <b>Aug 20, 1958</b> , and that death occurred at <b>11:55</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dr. Ford H. Sprecher M.D. 135 W. Main, Elkton, Md. Aug 21-58</b>							
ACTUAL SIGNATURE <b>Dr. Ford H. Sprecher</b>		PHYSICIAN'S NAME (Type) <b>Macford H. Sprecher M. D. 135 W. Main St., Elkton, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lawn Croft Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boothwyn, Del. Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Pippin</b>				24a. REC'D BY REGISTRAR <b>W. H. Pippin</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Pippin</b>	

AUG 26 1958



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08984

Reg. Dist. No.

8979

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>Wilmington</b> 46 X - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital DOA</b>		d. STREET ADDRESS <b>1201 Pleasant Street</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>S.</b> Last <b>Heiton</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 26, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machine Shop</b>	11. BIRTHPLACE (State or foreign country) <b>Scotland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Sewell Heiton</b>	
14. MOTHER'S MAIDEN NAME <b>no information</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>221-01-4468</b>		17. INFORMANT <b>Lillian Heiton</b> Address <b>Wilm, Del. 1201 Pleasant St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>3 minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. R. C. Dodson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8/17/58</b>	
EXAMINER'S NAME (Type) <b>Dr. R. C. Dodson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>8-17-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Memorial Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Farnhurst, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert J. McCrery</i>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '58</b>	
ADDRESS <b>Albert J. McCrery, Wilmington, Delaware</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

NO. 10

1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE THE EXAMINATION. IT IS TO BE FILED IN THE OFFICE OF THE COMMISSIONER OF HEALTH, ALBANY, NEW YORK.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08985

8993

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Cecil</b>		STATE <b>Md.</b>		COUNTY <b>Cecil</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Port Deposit, Rural</b>		LENGTH OF STAY (In this place) <b>38 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Port Deposit, Rural</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Route 222</b>		STREET ADDRESS (If rural give location) <b>Route 222</b>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>John Daniel Hodges</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>8 27 1958</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Aug. 5, 1894</b>	<b>9. AGE last birthday</b> <b>64 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>John D. Hodges</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unk.) (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-14-8305</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Edward Hodges, Port Deposit, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>422.2</b> IMMEDIATE CAUSE (A) <b>Chronic Myocarditis</b>						<b>6 yrs.</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>Bronchial Asthma</b>		<b>10 yrs</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21i. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Sept. 5, 1954</b> , to <b>Aug 6, 1958</b> , that I last saw the deceased alive on <b>Aug 5, 1958</b> , and that death occurred at <b>8:21 A.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Cesaire H. Hannon</b>		<b>M.D.</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Port Deposit, Md.</b>		<b>DATE SIGNED</b> <b>8-27-58</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>8-30-1958</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Cokesbury</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Port Deposit, Md. RFD</b>	
<b>24. REC'D BY REGISTRAR</b> DATE <b>AUG 29 '58</b>		<b>REGISTRAR'S SIGNATURE</b> <b>C. S. Hannon</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>V. A. Patterson</b> ADDRESS <b>Perryville, Md.</b>			



10033

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

# CERTIFICATE OF DEATH

10033

Reg. Dist. No.

LOCAL REGISTRAR (NAME OF REGISTRAR)

PLACE OF DEATH

John M. Cecil

MARYLAND

Cecil

John M. Cecil

John M. Cecil

John M. Cecil

Route 232

House 232

John M. Cecil

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INSTRUCTIONS



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>		c. LENGTH OF STAY IN 1b <b>all life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>High St.</b>		e. STREET ADDRESS <b>High St.</b>	
3. NAME OF DECEASED (Type or print) <b>Martha E Hyatt</b>		4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Guy B. Mackinson</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Hahn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>162-28-3261</b>	
17. INFORMANT <b>Cread F. Hyatt, North East. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-3-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>North East Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 13 '58</b>	
ADDRESS <b>North East Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

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*Journal of Management Education*

2000

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4. 1994年12月24日，在“94年12月24日”处，应填“1994年12月24日”。

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10/11/2007

## CERTIFICATE OF DEATH

08987

Reg. Dist. No.

8980

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9th Dist. Calvert, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp. Elkton, Md.</u>				d. STREET ADDRESS <u>9th Dist</u>			
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>W.</u> Last <u>Kidd</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. AGE (In years last birthday) <u>50</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>			
11. BIRTHPLACE (State or foreign country) <u>Lombard, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HARRY G. Kidd</u>				14. MOTHER'S MAIDEN NAME <u>Effie C. Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-12-0298</u>			
17. INFORMANT <u>Mrs. Paul Kidd</u>				Address <u>Calvert, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Aug. 9-58</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 1958, to August 9, 1958, that I lost the deceased alive on <u>Aug 9</u> , 1958, and that death occurred at <u>933</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Elkton, Md.</u>				DATE SIGNED <u>Aug 9-58</u>			
ACTUAL SIGNATURE <u>Dr. Paul H. Sprecher</u>				DATE SIGNED <u>Aug 9-58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Paul H. Sprecher</u>				DATE SIGNED <u>Aug 9-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 13, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert, Cecil, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed, Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 13 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08988

8995

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecil</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>Louise</b> Last <b>KNAPP</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-85</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>58</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service - Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Knapp</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte (?) Knapp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records, V.A. Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic brain syndrome associated with disease</b> <b>345X</b> DUE TO <b>of unknown or uncertain cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Multiple sclerosis</b> DUE TO <b>unknown</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>43</b> , to <b>August 7</b> , 19 <b>58</b> , and that death occurred at <b>9:35</b> a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>8-7-58</b>			
ACTUAL SIGNATURE <b>W. M. HARRIS</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. M. HARRIS</b>		Acting Director, Professional Services	
22a. BURIAL CREATION REMOVAL (Specify) <b>8/8/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Newburyport, Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. HINES</b>		ADDRESS <b>2901 - 14th St. N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>AUG 11 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hines</b>	

CERTIFICATE OF DEATH

1933

Reg. No. 100

1. Name of Deceased: [Illegible]

2. Sex: [Illegible]

3. Age: [Illegible]

4. Date of Birth: [Illegible]

5. Date of Death: [Illegible]

6. Place of Death: [Illegible]

7. Cause of Death: [Illegible]

8. Signature of Physician: [Illegible]

9. Signature of Registrar: [Illegible]

10. Date of Registration: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

8996

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo Rural</b>	
c. LENGTH OF STAY IN 1b <b>92 yrs.</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1866</b>
9. AGE (In years (at birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Riverman employed by Conowingo Power Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Conowingo Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Napoleon B. Lee</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Gertrude Hausman</b>		Address <b>Conowingo, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Uremia</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1953</b> to <b>8/26 1958</b> , that I last saw the deceased alive on <b>8/26 1958</b> , and that death occurred at <b>9 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Neil Taylor Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Neil Taylor Jr.</b>		DATE SIGNED <b>8/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 30, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Tyson</b>		ADDRESS <b>Rising Sun, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68990

Reg. Dist. No.

8997

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earville, R.D.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>visiting</b>		d. STREET ADDRESS <b>624 W. Berry St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sassafras River</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>D</b> Last <b>Lindsay.</b>		4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-1942</b>
9. AGE (In years last birthday) <b>15</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl. L. Lindsay</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Frank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Earl L. Lindsay.</b>		Address <b>624 W. Berry St. Balto. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowned</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>---</b> (c), stating the underlying cause lost. (c) <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>---</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was in bathing and sank and never came up</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> p. m. <b>8 4</b> 19 <b>58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) (County) (State) <b>Earville, R.D. Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8-6-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

195

• C. S. Collins

1072 3412333

1993

Abstract

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Index

Boy's Life

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>J.</b> Last <b>Mischler</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1875</b>
9. AGE (In years last birthday) <b>82</b>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Mischler</b>		14. MOTHER'S MAIDEN NAME <b>No record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Dorothy Zerbe</b>		Address <b>Elkton, Md. RFD # 3</b> <b>Singerly Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 8 days 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7-8</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>31 July</b> , 19 <b>58</b> , to <b>8 Aug</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 Aug</b> , 19 <b>58</b> , and that death occurred at <b>2:35</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecil, Md.</b> DATE SIGNED <b>8 Aug 58</b>			
ACTUAL SIGNATURE <b>Wallace Oshershein</b>		M.D. <b>Cecil, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lakeside Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Dover, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. T. Jones</b>		ADDRESS <b>Newark, Del.</b>	24a. REC'D BY REGISTRAR <b>AUG 12 1958</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krueger</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8998

CERTIFICATE OF DEATH

08992

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>M.</b> Last <b>Norman</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaacs Galloway</b>		14. MOTHER'S MAIDEN NAME <b>Hargraves</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Idella Jones</b>		Address <b>Charlestown, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> <b>201x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>201x</b> DUE TO (c) <b>201x</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Renal Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>-</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>58</b> , to <b>9 Aug</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 Aug</b> , 19 <b>58</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Klaus H. Huchner</b>		ADDRESS (Street, city or town, state) <b>North East, Md</b>	
DATE SIGNED <b>13 Aug '58</b>			
PHYSICIAN'S NAME (Type) <b>Klaus H. Huchner M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-13-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Charlestown</b>		22d. LOCATION (City, town, or county) (State) <b>Charlestown, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

8933

STATE OF MARYLAND DEPARTMENT OF HEALTH		COUNTY OF BALTIMORE	
NAME OF DECEASED JAMES H. HARRIS		SEX Male	
DATE OF DEATH 1911		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease	
PLACE OF BIRTH Baltimore, Md.		AGE 45	
OCCUPATION Clerk		MARITAL STATUS Single	
EDUCATION High School		RELIGION Protestant	
PREVIOUS ILLNESS None		MEDICAL HISTORY None	
PHYSICIAN'S SIGNATURE J. H. Harris		CORONER'S SIGNATURE J. H. Harris	
DATE OF SIGNATURE 1911		PLACE OF SIGNATURE Baltimore, Md.	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08993

8982

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>several years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital, Elkton, D.O.A.</b>				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernard Lalo Prevento</b>				4. DATE OF DEATH Month <b>8</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 29, 1918</b>		9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b>24</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fiber Mill worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fiber Manf.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andy Prevento</b>				14. MOTHER'S MAIDEN NAME <b>Mary Augustine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-16-5068</b>		17. INFORMANT <b>Enrico Prevento, Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> (c) <b>stating the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moore's Chapel Cemetery R. D. #3 Elkton, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Pippin Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Aug 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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8983

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 1/2 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl First Middle Last Racing				4. DATE OF DEATH Month Day Year Aug 16 1958			
5. SEX F		6. COLOR OR RACE Wh.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1958	
9. AGE (In years last birthday) yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME Fred D. Racine				14. MOTHER'S MAIDEN NAME Margaret A. Weiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Fred D. Racine				317 Hollingsworth Manor Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurely — 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 16, 1958, to Aug 16, 1958, that I last saw the deceased alive on Aug 16, 1958, and that death occurred at 5:58 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-19-1958		22c. NAME OF CEMETERY OR CREMATORY Betgel Cemetery	
22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home N. G. Lusby Elkton			
24a. REC'D BY REGISTRAR DATE AUG 19 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2083

Reg. Dist. No.

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

AGE

SEX

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08995

8999

Reg. Dist. No. 96

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN lb <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> <span style="float: right;">67X-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>J.</b> Last <b>RALEIGH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep. 7-24-92</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Maurice Raleigh</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Carlin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 135 03 8798</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary disease with infarction</b> <b>420.1</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO</p> <p>(c)</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>8-5-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/8/58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Beverly National</b>		22d. LOCATION (City, town, or county) (State) <b>Beverly, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 13 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Post-mortem Examination		Toxicology		Microscopic Examination	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and is to be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film G232 8-20-58 at

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 27yrs.7mo.26days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1815 N. Gay Street	
3. NAME OF DECEASED (Type or print) First MIDDLE REILLY Last		4. DATE OF DEATH Month August Day 13 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Reilly		14. MOTHER'S MAIDEN NAME Mary Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized severe DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 18, 1958, to August 13, 1958, and that death occurred at 12:25a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md. 8-13-58 PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-16-58		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
22d. LOCATION (City, town, or county) Baltimore County		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul Street, Baltimore, Md.		24a. REC'D BY REGISTRAR AUG 13 58	
24b. REGISTRAR'S SIGNATURE			



# CERTIFICATE OF DEATH

1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Case No. 111

Name of Deceased		John A. Kelly	
Sex		Male	
Age		35	
Date of Birth		August 13, 1865	
Place of Birth		Maryland	
Usual Residence		Baltimore	
Cause of Death		Hypertensive cardiovascular renal disease	
Immediate Cause		Hypertensive cardiovascular renal disease	
Intermediate Cause		Hypertensive cardiovascular renal disease	
Underlying Cause		Hypertensive cardiovascular renal disease	
Date of Death		August 13, 1900	
Place of Death		Baltimore	
Signature of Physician		J. H. Hensel, M.D.	
Signature of Registrar		J. H. Hensel, M.D.	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT, CHAP. 23, SECT. 10, OF THE MARYLAND CODE, 1900, AS AMENDED.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G233 9-5-58 et.

CERTIFICATE OF DEATH

8984

08997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
c. LENGTH OF STAY IN 1b <u>2</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Geneva</u> Middle _____ Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Madison, Maine</u>	
13. FATHER'S NAME <u>J. Mahlon Luce</u>		14. MOTHER'S MAIDEN NAME <u>Florence Spaulding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-16-9974</u>		17. INFORMANT <u>Birth Certificate, Vera Adams</u> Address <u>Madison, Maine</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Papillary adenocarcinoma of the ovary</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>unknown</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 21</u> , 19 <u>58</u> , to <u>Aug. 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 15</u> , 19 <u>58</u> , and that death occurred at <u>5:15 p. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. <u>233 E. Main St.</u> <u>8/16/58</u> PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u> <u>Elkton, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 17, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	
22d. LOCATION (City, town, or county) <u>North East, Cecil Co.</u>		(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Grant</u>					

CERTIFICATE OF DEATH

1988

FILE NO.

DATE

PLACE OF DEATH

DATE OF DEATH

DECEASED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

9001

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
c. LENGTH OF STAY IN 1b <u>5 month</u>		d. STREET ADDRESS <u>1513 Crest Road, Penn Wynne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>RICH</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-01</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Promoter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry S. Rich - Deceased</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mumma - Deceased</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>572.1 Peritonitis localized lower abdomen due to ruptured diverticulum and ulcerative colitis</u> DUE TO (b) <u>Coronary heart disease, severe, with myocardial thrombosis left ventricle</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized severe - unknown</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>VA</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4</u> , 19 <u>58</u> , to <u>August 3</u> , 19 <u>58</u> and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>8-4-58</u>	
PHYSICIAN'S NAME (Type) <u>S. P. LACERVA</u>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/6/58</u>		22b. DATE THEREOF <u>8/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington &amp; Son, Havre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 8 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8985

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton, R.D.#3	
		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie C. Scarborough		4. DATE OF DEATH Month Day Year Aug 6 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890
		9. AGE (In years, last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Brennan		14. MOTHER'S MAIDEN NAME DeLilah De Vore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
		17. INFORMANT Address Miss Doris Ann Scarborough, Elkton, R.D. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary - Pulmonary Edema DUE TO (b) Cerebrovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 June 1958, to 6 Aug 1958, that I last saw the deceased alive on 4 Aug 1958, and that death occurred at 12:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Kveis, Jr.		ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) George J. Kveis, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Leeds Cemetery	22d. LOCATION (City, town, or county) (State) Leeds Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	24a. REC'D BY REGISTRAR DATE AUG 14 '58
			24b. REGISTRAR'S SIGNATURE Arthur S. Hawk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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9002

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09000

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>GEORGIA</b> b. COUNTY <b>Chatham</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY in 1b <b>5yrs4mos30days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SAVANNAH</b> <b>49X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>727 Waters Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>D.</b> Last <b>SHERMAN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-19</b>
9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK SHERMAN</b>		14. MOTHER'S MAIDEN NAME <b>WILHEMINA DORSEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>		16. SOCIAL SECURITY NO. <b>260 0109 07</b>	
17. INFORMANT <b>Hospital Records, VA Hosp., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia, right lower lobe</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 to 3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. DODSON</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. DODSON, M.D.</b>		DATE SIGNED <b>August 30, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/31/58</b>		22b. DATE THEREOF <b>Unburied</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Savannah, Georgia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Percy H. Hand</b>		ADDRESS <b>SEP 3 '58</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

09001

8986

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East, Md.	
3. NAME OF DECEASED (Type or print) Sarah First Middle Last ESTHER SMITH		4. DATE OF DEATH Month 8 Day 7 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pleasant Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Starrett Smith		14. MOTHER'S MAIDEN NAME Emma Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Walter I Smith, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Myocardial Failure DUE TO (b) C.V.A. Cerebral hemorrhage DUE TO (c) Hypertensive Cardiovascular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phosia Kidney, Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 15 min 2 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-5, 1958, to 8-7, 1958, that I last saw the deceased alive on 8-7, 1958, and that death occurred at 3:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.		North East, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-12-58	22c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Elkton (Rural) Cecil Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. B. Grant		ADDRESS North East, Maryland.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 13 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8386



NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1888"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Clerk"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		DATE OF DEATH [Faint text, possibly "10-20-1918"]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
SIGNATURE OF JURY [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	
SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF DEPUTY CLERK [Faint signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09002

Reg. Dist. No.

9003

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Herman R.C.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, R.D.</b>	
c. LENGTH OF STAY IN 1b <b>enroute</b>		d. STREET ADDRESS <b>Port Herman and Town Point Road.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Oliver Sullivan</b>		4. DATE OF DEATH Month Day Year <b>8 19 19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-20-1937</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Thiacol Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>F. Robert Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>M. Grace Woodworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-36-1152</b>	
17. INFORMANT <b>Robert O. Sullivan, Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Skull</b> <b>823X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car left the road and hit tree</b>	
20c. TIME OF INJURY Month, Day, Year <b>6.40 p.m. 8 19 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
20f. (City or town) <b>Port Herman</b>		(County) <b>Cecil</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8-20-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 8/22/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Douglas H. Woodworth</b>		24a. REC'D BY REGISTRAR <b>Aug 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1903

County of \_\_\_\_\_ State of \_\_\_\_\_

Decedent's Name \_\_\_\_\_

Place of Birth \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

Date of Death \_\_\_\_\_

Place of Death \_\_\_\_\_

Signature of Medical Examiner \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of \_\_\_\_\_

Our full and true

Signature \_\_\_\_\_

Signature \_\_\_\_\_

x

Signature \_\_\_\_\_

x

Signature \_\_\_\_\_

9004

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>Newcastle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Calvert</b>		c. LENGTH OF STAY IN 1b <b>Wilmington</b> 46 X - 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 273 and 272</b>		d. STREET ADDRESS <b>1716 Newport Gap Pike</b>	
3. NAME OF DECEASED (Type or print) <b>Alta</b> First <b>Harmon</b> Middle <b>Tweddle</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-1911</b> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Harmon</b>		14. MOTHER'S MAIDEN NAME <b>Martha Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>222-14-7283</b>	
17. INFORMANT <b>Harrison H. Tweddle</b>		Address <b>Wilmington</b> <b>1602 W. 14th. Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest and Multiple contusions</b> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car was hit at intersection</b>	
20c. TIME OF INJURY Month, Day, Year <b>7</b> <b>8 16 19</b> Hour <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 273</b>		20f. (City or town) <b>Calvert</b> (County) <b>Cecil</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silver Brook Cem.</b>		22d. LOCATION (City, town, or county) <b>Wilmington</b> (State) <b>NewCastle Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Tyson</b> ADDRESS <b>Picnic Lane, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 19 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1905

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

AGE

SEX

Wilmington

Male

1715 Newcomb Gas Pipe

Post-Office Box 212

Wesley

Marion

Alfred

11-0-1911

Marion

W

Maryland

Housewife

Marion Norton

Charles F. Norton

Wilmington

Marion H. Wesley, John W. West, Del.

(222-1)-(222)

no

Caused death and multiple contusions

Car was hit at intersection

Delivered

Post-Office Box 212

8-16-23

7

2-1-23

no

W.C. Tolson

Washington, D.C.

Delivered to

2-2-23

Marion

9005

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09004

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>NewCastle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> 46 X-9	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 273 and 272</u>		d. STREET ADDRESS <u>1716 Newport Gay. Pike</u>	
3. NAME OF DECEASED (Type or print) <u>Augustus Springer Tweddle</u>		4. DATE OF DEATH <u>8</u> <u>16</u> <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>18</u> Hours <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Tch.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Her. Powder Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Tweddle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Springer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-03-8419</u>	
17. INFORMANT <u>Harrison H. Tweddle</u>		Address <u>Wilmington, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest Ouncrure left arm.</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>His car was hit by another</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-05</u> <u>8</u> <u>18 58</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 273</u>		20f. (City or town) <u>Calvert</u> (County) <u>Cecil</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		DATE SIGNED <u>8-17-58</u>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Silver Brook Cem.</u>		22d. LOCATION (City, town, or county) <u>Wilmington NewCastle</u> (State) <u>Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Tyson, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 19 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Klaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3000 2000 1000 0

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Estimated

Robert A. Kessel

James Springer

21-60-555

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THESE ARE THE RESULTS OF THE STUDY:

632 *Journal of Management Inquiry* 16(6)

— 262 —

model G-G-5

100% 100%

497

Editorial Board: Not published.

52-75

FOR STATE  
HEALTH DEPT.

9006

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Delaware		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earlville R.D.		c. LENGTH OF STAY IN 1b 3 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield 75x-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Long Point			d. STREET ADDRESS 328 N. Croft St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Norma First Middle Last Mae Woolford			4. DATE OF DEATH Month 8 Day 31 Year 19 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1910		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comptometer Oper.		10b. KIND OF BUSINESS OR INDUSTRY Rome Cable Corp.		11. BIRTHPLACE (State or foreign country) Orange Mass.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Taylor			14. MOTHER'S MAIDEN NAME Eva M. Patterson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT C. Edward Woolford, 328 N. Craft St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left Lung. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-31-58	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-31-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	
22d. LOCATION (City, town, or county) Delaware Co. Penna.		22e. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home			
23. ADDRESS Pippin Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 4 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

8000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1922		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		CATHOLIC CHURCH		JAN 18 1922	
MARITAL STATUS		EDUCATION		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM		SIGNATURE OF EXAMINER	
MARRIED		HIGH SCHOOL		NONE		NONE		NONE		J. H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
JAN 15 1877		BALTIMORE, MD.		JAN 15 1922		BALTIMORE, MD.		JAN 18 1922		CATHOLIC CHURCH	
DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 16 1922		BALTIMORE, MD.		JAN 16 1922		BALTIMORE, MD.		JAN 16 1922		BALTIMORE, MD.	
DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 16 1922		BALTIMORE, MD.		JAN 16 1922		BALTIMORE, MD.		JAN 16 1922		BALTIMORE, MD.	

RECEIVED  
JAN 16 1922

*Handwritten signature*

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

9007

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LILLARD</b> Middle <b>O.</b> Last <b>WYATT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 5, 1916</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wyatt</b>		14. MOTHER'S MAIDEN NAME <b>Melissa Baldwin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>230-10-5742</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>545X</b> IMMEDIATE CAUSE (a) <b>Peritonitis diffuse and localized, subacute chronic</b> DUE TO <b>due to extravasated contents of viscera</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Gastrojejunostomy (5-12-58)</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 15</b> , 19 <b>58</b> , to <b>August 15</b> , 19 <b>58</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>8-15-58</b> ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. <b>Director, Professional Services</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/18/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Havre de Grace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 19 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

